DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9798

Registration District No. FILE APR 12 1940 399

Primary Registration District No. 1002

Registrar's No. 1232

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 1 x19511

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C.General Hospital No.1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 2627 E. 6th St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

8. (a) PRINT FULL NAME Mary Porter 636

8. (b) If veteran, name war No

8. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife --

6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased Sept. 24, 1939 (Month) (Day) (Year)

8. AGE: Years --; Months 5; Days 23; If less than one day ____ hr. ____ min.

9. Birthplace K. C. Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation Baby

11. Industry or business

FATHER
12. Name Hill Porter
13. Birthplace Carthage, Mo. (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Marie Mallecoat
15. Birthplace Rogersville, Mo. (City, town, or county) 0 (State or foreign country)

16. (a) Informant's own signature Vernon E. Smith
(b) Address 2627 E. 6th

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-19-40 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director Sheil Funeral Home
(b) Address City

19. (a) Mch 19 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17th year 1940 hour 9 minute 55 A.M. M.

21. I hereby certify that I attended the deceased from 3-9-40, 19__, to 3-17-40, 19__; that I last saw her alive on 3-16-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lobar pneumonia	8
Due to: 106	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	PHYSICIAN
Of autopsy: See above	Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature E. F. DeMoss MD (M. D. or other)
Address Supt. K.C.Gen.Hosp., K.C.,Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Joe B. Yoder, Registered Apprentice No. #233,

working under my personal supervision.

Signed J. R. Sheil

Licensed Embalmer No. 3625

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.